Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ACS PRIMARY CARE PHYSICIANS
3585 RIDGE PARK DR
AKRON OHIO 44333

Respondent Name
UTICA MUTUAL INSURANCE CO

Carrier's Austin Representative Box
Box Number 01

MFDR Tracking Number
M4-13-0853-01

MFDR Date Received
December 4, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This claim is being sent for reconsideration due to the fact; ACS originally billed this out to the employer for carrier information. This was returned for wrong address. Return date stamped on documentation enclosed. Updated to new address on charge and resent to employer. ACS did not have any reply from the carrier or employer… Pursuant to Texas Worker's Comp law, a provider of service has 95 days a bill may be subject to workers' compensation to bill, as long as it is billed within 95 days. The attached Billing Ledger shows our office meets these requirements…"

Amount in Dispute: $862.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to the request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 23, 2012	Emergency Room Services	$862.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out the guidelines for medical bill submission by the health care provider
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 29 – The time limit for filing has expired.
   - 892 – Billed date exceeds 95 days from date of service
   - 18 – Duplicate claim/service.
   - 224 – Duplicate charge.

Issues

1. Did the Requestor submit medical bills to the employer?
2. Did the requestor forfeit the right to medical dispute resolution as provided by Labor Code §413.031?

Findings

1. Per 28 Texas Administrative Code § 133.20(J)(1)(C) A health care provider who elects to submit medical bills to an employer waives, for the duration of the election period, the rights to: medical dispute resolution as provided by Labor Code §413.031..." Review of the documentation submitted by the requestor finds that the original medical bill was submitted to the employer. For that reason, the requestor in this dispute has waived the right to medical dispute resolution.
2. The requestor forfeits the right to medical fee dispute resolution. As a result the amount ordered is $0.00

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	August 15, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.